MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ C9846

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 6 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1112 Wolfe Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: LILLIE MAY ALLEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 8, 1926

8. AGE: Years	Months	Days	If less than one day
20	5	21	hrs. min.

9. Birthplace: Raleigh, N. C.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: Robert Allen
13. Birthplace: Raleigh, N. C.

MOTHER
14. Maiden name: Ethel Avery
15. Birthplace: Raleigh, N. C.

16. Informant: Deceased
Address

17. Buried (Burial, cremation, or removal. Which?) Date thereof 11/3/46 (month) (day) (year)
Cemetery or crematory: Elias Cemetery
Location: Wake Co. Raleigh, N.C.
18. Funeral director: Elroy O. Wilson
Address: 1000 Brantley ave

19. 10/29 (Date rec'd by registrar) 19 46 Albert R. Swanbaum Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29, 19 46 at 2.10P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 23, 19 46, to Oct., 29, 19 46 and that I last saw her alive on October 29, 19 46

Immediate cause of death: Pulmonary Tuberculosis — DURATION: March 1945

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Ruben W. Swan, M.D. M. D. or other
Address: Henryton, Md. Date signed: 10/29/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45


RECEIVED
NOV 2 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09847

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Adelaide Jenkins Anderson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed

6.(b) Name of husband or wife Thomas M. Anderson
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1868

8. AGE: Years	Months	Days	If less than one day
78	9	9	hrs. min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home

FATHER
12. Name Joshua Wrightt
13. Birthplace England

MOTHER
14. Maiden name Jane Jenkins
15. Birthplace England.

16. Informant Mrs. Hyde Waltjen
Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 28 1946 (month) (day) (year)
Cemetery or crematory Prospect Hill Cemetery
Location Lawson, Md.

18. Funeral director C. Harry Wm
Address Sykesville, Md.

19. Oct 27 1946 (Date rec'd by registrar) C. Harry Wm Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1946, at 11:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935 1946, to Oct 25 1946 and that I last saw her alive on Oct. 25 1946

Immediate cause of death	DURATION
General Cardio vascular disease with arteriosclerosis	
Due to Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. H. Lawood M.D.
M. D. or other
Address Sykesville Date signed 10-25-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
NOV 1 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9

09848

CERTIFICATE OF DEATH

★ Reg. Dist. No. 80

1. PLACE OF DEATH:
County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Richard Lewis Baker

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4- 1946

8. AGE: Years	Months	Days	If less than one day
	1	10	hrs. min.

9. Birthplace Hanover, Penna.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Charles O. Baker
13. Birthplace Maryland

MOTHER 14. Maiden name Almeda Reider
15. Birthplace Maryland

16. Informant C. O. Baker
Address New Windsor, Md.

17. Burial Date thereof Oct 16-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Church of God Cemetery
Location Uniontown, Md.

18. Funeral director H. H. Fuhrman & Sons
Address Union Bridge & New Windsor Md.

19. Oct 16 1946 Emma B. Bell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1946, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 4 1946 to Oct 14 1946
and that I last saw him alive on Oct 14 1946

Immediate cause of death	DURATION
Whooping Cough	3 wks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. H. Legg M. D. or other
Address Union Bridge Date signed 10-15-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 09849

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 20 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D #4
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ANNA REBECCA BELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 18, 1918

8. AGE: Years	Months	Days	If less than one day
28	2	29	hrs. min.

9. Birthplace: Martinsburg, W. Va.
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:
FATHER 12. Name: Jasper Bell
13. Birthplace: Unknown
MOTHER 14. Maiden name: Masie Jackson
15. Birthplace: Unknown
16. Informant: Deceased
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: oct 21 46 (month) (day) (year)
Cemetery or crematory: norbeck md
Location: Montgomery Co
18. Funeral director: Robert L. Snowden
Address: Rockville md
19. 10/17 1946 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17, 1946 at 6.20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27, 1946 to Oct., 17, 1946 and that I last saw her alive on October 17, 1946

Immediate cause of death: Pulmonary Tuberculosis — DURATION: June 1946

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Offman M.D. M. D. or other
Address: Henryton, Md. Date signed: 10/17/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

C9850

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Rural - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Francis Lloyd Bennett

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 16, 1873

8. AGE:

Years	Months	Days	If less than one day
73	0	22	hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Agriculture

FATHER 12. Name John Wm Bennett

13. Birthplace Md

MOTHER 14. Maiden name Sarah Lloyd Saunders

15. Birthplace Md

16. Informant Mrs Sarah A Brough

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 11 1946 (month) (day) (year)

Cemetery or crematory Springfield Cemetery

Location Sykesville, Md.

18. Funeral director C. Harry Wenz

Address Sykesville, Md.

19. Oct 9 1946 C. Harry Wenz

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1946 at 11:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 19 to death 19

and that I last saw h. i. m. alive on 10/8/46 19

Immediate cause of death	DURATION
Renal cardio vascular disease	
with arteriosclerosis -	
Due to senile changes	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. K. Lawson M.D.

M. D. or other

Address Sykesville, Md Date signed 10/8/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-0)

CERTIFICATE OF DEATH

09851

Reg. Dist. No. 70

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Taneytown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Nathan Blume

3.(b) Social Security Number: 219-20-1806

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ida Blume

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 15, 1893

8. AGE:

Years	Months	Days	If less than one day
53	1	22	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Shoe factory worker

11. Industry or business

FATHER — 12. Name: Augustus Blume

13. Birthplace: Md

MOTHER — 14. Maiden name: Josephine Brightwell

15. Birthplace: Md

16. Informant: Mrs William Blume

Address: Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 10, 1946 (month) (day) (year)

Cemetery or crematory: Baughs Cemetery

Location: Ladiesburg, Md.

18. Funeral director: C O Gust & Son

Address: Taneytown, Md.

19. Oct 8. 1946 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7 1946, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cardio-Vascular renal disease	years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James T. Shoved, Deputy Medical Examiner M. D. or other

Address: Westminster Md Date signed: 10-7-46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

09852

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 4 mo., 4 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 1 yr., 4 mo., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Unk

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Raymond Elwood Case

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of husband or wife: Sophia Rachel Moore

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 23, 1887

8. AGE: Years	Months	Days	If less than one day
59	5	16	..... hrs. ..... min.

9. Birthplace: Wheaton, Maryland (Town, county, and state)

10. Usual occupation: farmer

11. Industry or business: agriculture

FATHER — 12. Name: Samuel Case

FATHER — 13. Birthplace: Howard County, Maryland

MOTHER — 14. Maiden name: Minerva Harding

MOTHER — 15. Birthplace: Maryland

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. ~~Removal~~ Burial (Burial, cremation, or removal. Which?) Date thereof 10-12-46 (month) (day) (year)

Cemetery or crematory: Union Cemetery

Location: Burtonsville Md.

18. Funeral director: Warner E. Pumphrey

Address: 8434 Ga. Ave Silver Spring

19. Oct. 9 1946 (Date rec'd by registrar) C. Haley Owen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9 1946, at 6:45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 1946, to Oct. 9 1946 and that I last saw him alive on October 8 1946

Immediate cause of death	DURATION
Arteriosclerosis	2 yrs.
Due to	
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.

Springfield State Hospital M. D. or other

Address: Sykesville, Maryland Date signed: 10-9-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09853

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 22 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 18 N. Eden Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: FRANK CLARK

3.(b) Social Security Number: 219-16-7211

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Mary Clark
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): May 13, 1893

8. AGE: Years	Months	Days	If less than one day
53	5	16	...hrs. ...min.

9. Birthplace: Hollywood, Md. (Town, county, and state)
10. Usual occupation: Cook
11. Industry or business:

FATHER
12. Name: James Clark
13. Birthplace: St. Mary's Co., Md.

MOTHER
14. Maiden name: Percella Stewart
15. Birthplace: St. Mary's Co., Md.

16. Informant: Deceased
Address:

17. (Burial, cremation, or removal. Which?) Burial Date thereof Nov. 2, 1946 (month) (day) (year)
Cemetery or crematory: Hollywood Md
Location: St. Mary's Co Md
18. Funeral director: Elroy O. Wilson
Address: 1000 Brantly ave

19. (Date rec'd by registrar) 10/29 1946 Albert M. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29, 1946 at 5.15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7, 1946 to Oct., 29, 1946 and that I last saw him alive on October 29, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1945
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 10/29/46

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09854

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6years2months7days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 6years2months7days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2205 W. Lexington St.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME: Philip Costanzo

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	divorced

6.(b) Name of husband or wife: Unk-
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 6, 1894

8. AGE: Years	Months	Days	If less than one day
51	11	2	hrs. min.

9. Birthplace: Italy
(Town, county, and state)
10. Usual occupation: laborer
11. Industry or business: railroad

FATHER
12. Name: Joseph Costanzo
13. Birthplace: Italy

MOTHER
14. Maiden name: Marie Anani
15. Birthplace: Italy

16. Informant: Springfield State Hospitalrecord
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/10/46 (month) (day) (year)
Cemetery or crematory: Springfield Cemetery
Location: Sykesville, Md.
18. Funeral director: C. Harry Weis
Address: Sykesville, Md.

19. Oct. 9 (Date rec'd by registrar) 19 46 C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8 19 46 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 19 46 to October 8 19 46 and that I last saw him alive on October 8 19 46

Immediate cause of death	DURATION
Lung abscess	6 mos.
Due to	
Due to	
Other conditions: General Paralysis of the Insane	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: Lung abscess
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Robert Bertrand May, M.D.
23. SIGNATURE: Robert Bertrand May, M.D.
M. D. or other
Springfield State Hospital
Address: Sykesville, Maryland Date signed: 10-9-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74-a

CERTIFICATE OF DEATH

09855

Reg. Diat. No. 831

1. PLACE OF DEATH:
County: Carroll
City or town: Mens Woodbine
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Woodbine - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth E. Dorsey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: Edward W. Dorsey
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Feb'y 2, 1887

8. AGE: Years: 59 | Months: 8 | Days: 12 | If less than one day: ...hrs. ...min.

9. Birthplace: Montgomery Co. Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Addison Ray
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Burras
15. Birthplace: Maryland

16. Informant: Mr. Edward W. Dorsey
Address: Woodbine, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 10-17-46 (month) (day) (year)
Cemetery ~~or crematory~~: St. Michaels
Location: Poplar Springs, Howard Co. Md.

18. Funeral director: C. M. Watts
Address: Winfield, Md.

19. Oct-16 1946 (Date rec'd by registrar) Edna M. Dewitt Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14, 1946, at 2:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1946, to Oct 14 1946
and that I last saw h~~er~~ alive on Oct 13 1946

Immediate cause of death	DURATION
Due to: Spleno-Myelogenous Leukemia	1 yr
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Splenectomy Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other
Address: Mt Airy, Md. Date signed 10/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

CERTIFICATE OF DEATH

Reg. Diat. No. 098596

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Westminster (Bachman's Valley Rd.)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? -----

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 34 W. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Sylvester Wesley Fisher

3.(b) Social Security Number: 220-16-2317

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 15, 1922

8. AGE: Years	Months	Days	If less than one day
24	2	20	hrs. min.

9. Birthplace: Carroll County, Maryland (Town, county, and state)

10. Usual occupation: labor

11. Industry or business:

FATHER — 12. Name: Not known —

13. Birthplace:

MOTHER — 14. Maiden name: Myrtle R. Fisher

15. Birthplace: Maryland

16. Informant: Myrtle R. Trite

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 10/7/46 (month) (day) (year)

Cemetery or crematory: Stone Chapel Cemetery

Location: Warfieldsburg, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 10/7 19 46 (Date rec'd by registrar) Registror

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 5, 1946, at 1:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/5 1946 to 10/5 1946 and that I last saw h alive on Did not see him alive

Immediate cause of death	DURATION
Fracture of Cervical Spine —	3 Minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 10/5/46

Where did injury occur? Bachman's Valley (City or town) Carroll (County) Maryland (State)

Injured at home, farm, industry, public place (where?): Riding in Truck

Means of injury: Thrown from Truck in Collision Injured at work? No.

23. SIGNATURE: Walter Bare M.D.

Active deputy Medical Examiner

M. D. or other

Address: Westminster, Md. Date signed: 10/5/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

(BC) (5) 9857

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yr. 3 mon. 13 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 yr. 3 mon. 13 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Jeffery Fitzgerald

3.(b) Social Security Number: 218-03-5821

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 3, 1881

8. AGE: Years	Months	Days	If less than one day
65	9	18	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Railroad Worker
11. Industry or business

FATHER
12. Name: Jeffery Fitzgerald
13. Birthplace: Ireland

MOTHER
14. Maiden name: Ellen
15. Birthplace: Ireland

16. Informant: Records.
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 25-1946 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Frederick Rd.

18. Funeral director: Krause Funeral Home
Address: 1216 S. Charles St.

19. Oct 22 1946 C. Gregory Evans
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 21, 1946, at 3:00p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 4, 1946, to October 21 1946 and that I last saw him alive on October 21, 1946

Immediate cause of death	DURATION
Arteriosclerosis	2 yrs
Due to:	
Due to:	
Other conditions: Psychosis with Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	2 yrs

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
M. D. or other
Address: Sykesville, Md. Date signed: 10-22-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 09858

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: EDWARD MATTHEW FRAZIER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 22, 1921

8. AGE: Years	Months	Days	If less than one day
25	2	11	..... hrs. ..... min.

9. Birthplace: Gaithersburg, Md. (Town, county, and state)
10. Usual occupation: Fireman
11. Industry or business

FATHER
12. Name: Nace Frazier
13. Birthplace: Montgomery County, Md.

MOTHER
14. Maiden name: Ella Handy
15. Birthplace: Montgomery County, Md.

16. Informant: Deceased
Address

17. Burial, cremation, or removal (which?) Buried Date thereof Oct 5 1946 (month) (day) (year)
Cemetery or crematory Chapel and St. Mary's
Location near Gaithersburg Rockville
18. Funeral director Pickett & Lowe
Address Rockville Md

19. Oct. 3, 1946 (Date rec'd by registrar) Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 3, 1946, at 9:35A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 12, 1946, to Oct. 3, 1946 and that I last saw him alive on October 3, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Reuben Offutt, M.D. (M. D. or other)
Address: Henryton, Md. Date signed: 10-3-46

M

I

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH ★

2411 N. Charles St., Baltimore 30-6

09859

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 5 mon. 11 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 1 yr. 5 mon. 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Hagerstown, Maryland REDS

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Fiddlersburg Md

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Robert Henry Garlock

3.(b) Social Security Number: 414-09-6026

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Leola Garlock

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): April 28, 1906

8. AGE:

Years	Months	Days	If less than one day
40	6	1	..... hrs. ..... min.

9. Birthplace: Fiddlersburg, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER

12. Name: William Garlock

13. Birthplace: Hagerstown Md

MOTHER

14. Maiden name: Anna Smith

15. Birthplace: Shrapsburg Md

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/31/46 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Hagerstown Md

18. Funeral director: H. K. Hoffman

Address: Hagerstown Md.

19. Oct. 30 1946 (Date rec'd by registrar) C. Henry Ebert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29, 1946, at 10:40 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 25, 1945, to Oct. 29, 1946 and that I last saw him alive on October 29, 1946

Immediate cause of death	DURATION
Tabo-paresis	
Due to	
Due to	
Other conditions: Tabo-paresis	6 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May MD

Springfield State Hospital M. D. or other

Address: Sykesville, Maryland Date signed 10/29/46

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 09860

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years, 5 mos., 28 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 7 years, 5 mos., 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Lillie Gladwell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Walter L. Gladwell (dec.)

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 7/10/1870

8. AGE: Years	Months	Days	If less than one day
76	3	20	hrs. min.

9. Birthplace: Baltimore County, Maryland
(Town, county, and state)

10. Usual occupation: None.

11. Industry or business:

FATHER
12. Name: Charles H. Bowen
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lydia Anne Fair
15. Birthplace: Pennsylvania

16. Informant: Records of Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 2-1946 (month) (day) (year)

Cemetery or crematory: Baltimore

Location: Baltimore, Maryland

18. Funeral director: Burgee Funeral Home

Address: 3631 Falls Road

19. Oct. 30 1946 (Date rec'd by registrar) C. Harry Zeller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/30 1946, at 8:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/16 1942, to 10/30 1946

and that I last saw her alive on 10/30 1946

Immediate cause of death: Arnold H. Eichert
Gallbladder
Cancer of the Stomach — DURATION: Known 1 week

Due to:

Due to:

Other conditions: Psychosis & Cerebral Arteriosclerosis — DURATION: 8 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Carcinoma of Gallbladder, Peritoneal metastases

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M. D. or other

Address: Springfield State Hospital, Sykesville, Maryland Date signed: 10/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1930

CERTIFICATE OF DEATH

09861

Reg. Dist. No. 63

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Rural ---Woodbine
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural ---Woodbine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JOHN WILLIAM GLENNAN

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 31, 1874

8. AGE: Years 72 | Months 6 | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER — 12. Name: Michael Glennan
13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mahala P. Brandenburg
15. Birthplace: Maryland

16. Informant: Mrs. Edna M. Hewitt
Address: Woodbine, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 10-19-46 (month) (day) (year)
Cemetery ~~or crematory~~: Brandenburg
Location: Berrett, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. Oct 19 (Date rec'd by registrar) 19 46 Edna M. Hewitt Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 16, 1946, at 10 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1st 1945 to Oct 16. 1946
and that I last saw h... alive on Oct 12th 1946

Immediate cause of death	DURATION
Acute Cardiac Dilatation	4 hrs.
Due to Myocardial Changes	6 mos.
Due to Chronic Cystitis	16 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Lehan R. Fout M.D. M. D. or other
Address: Westminster, Md. Date signed 10-17-46

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09862

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Springfield State Hospital
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 44 years, 11 months, 1 day
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 44 years, 11 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Hamilton

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 25, 1860

8. AGE: Years	Months	Days	If less than one day
86	5	21	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Daniel Ahern
13. Birthplace: Ireland

MOTHER
14. Maiden name: Rosa Hackett
15. Birthplace: Ireland

16. Informant: Hospital record
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-19-46 (month) (day) (year)
Cemetery or crematory: Holy Cross Cem.
Location: Balto. Md.
18. Funeral director: William Cook, Inc.
Address: 1217 N. Paul St. Balto. Md.
19. Oct 17 1946 C. Harry Elwes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16, 1946, at 6.52 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 1942, to October 16 1946 and that I last saw her alive on October 16, 1946

Immediate cause of death	DURATION
arteriosclerosis	
chronic myocarditis	10 yrs
Due to suppurative parotitis	
bilateral	7 days
Due to	
Other conditions: Manic depressive psychosis	44 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Irene Hildreth M.D.
M. D. or other
Address: Springfield State Hospital Date signed: 10-16-46

VS A15 9-45.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for the change of date of birth ~~and age~~ is shown on

09863

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

FILM No. I 08 OCT 28 1946

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo., 6 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

How long in hospital or institution? same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1705 Brentwood Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Thomas Hatchett

3.(b) Social Security Number: 212-10-5906

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 5, ~~1891~~ 1896

8. AGE: Years	Months	Days	If less than one day
50 ~~50~~	0	17	hrs. min.

9. Birthplace: Crew, Va.
(Town, county, and state)

10. Usual occupation: farmer

11. Industry or business:

FATHER
12. Name: Samuel Hatchett
13. Birthplace: Crew, Va.

MOTHER
14. Maiden name: Laura Tugule
15. Birthplace: Crew, Va.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 10-25-46 (month) (day) (year)

Cemetery or crematory: Crew Va.

Location:

18. Funeral director: A. Lothus Hahtad

Address: 918 Druid Hill Ave.

19. Oct. 22 1946 (Date rec'd by registrar) Albert R. Swankhaus deputy local Registrar

MEDICAL CERTIFICATION

a

20. DATE OF DEATH: Oct. 22 1946, at 5:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 16 1946 to Oct. 22 1946 and that I last saw h im alive on Oct. 22 1946

Immediate cause of death	DURATION
Pulmonary tuberculosis	8/1/46
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 10-22-46

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09864

Reg. Dist. No. 7H

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Benjamin Hellings

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B.(b) Name of husband or wife:
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2/13/1884

8. AGE: Years	Months	Days	If less than one day
62	7	24	hrs. min.

9. Birthplace: South Dakota (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business:
FATHER 12. Name: Benjamin Hellings
13. Birthplace: South Dakota
MOTHER 14. Maiden name: Marian Watts
15. Birthplace: Unknown
16. Informant: Records of Springfield State Hospital
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/10/46 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cem.
Location: Balto. Md.
18. Funeral director: Milton Lehilling
Address: 3914 E. Hanover St. Balto Md
19. Oct 7 1946 C. Harry Weed
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/7/ 19 46 at 8:20 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9/28/ 1946 to 10/7/ 1946 and that I last saw h... im alive on 10/7/ 1946

Immediate cause of death	DURATION
Paresis	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold N. Eichert M.D
M. D. or other
Address: Springfield State Hospital Sykesville, Maryland
Date signed: 10/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

69865

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 18 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1022 N. Eden Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: THOMAS HILL

3.(b) Social Security Number: 215-09-9246

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Lelia Hill
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June (?) 1898

8. AGE: Years	Months	Days	If less than one day
48	4	?	hrs. min.

9. Birthplace: Brunswick Coonty, Va.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: John Hill
13. Birthplace: Brunswick County, Va.
MOTHER 14. Maiden name: Bettie Alice Blackburn
15. Birthplace: Brunswick County, Va.
16. Informant: Deceased
Address:
17. Shipped (Burial, cremation, or removal. Which?) Date thereof 10/24/46 (month) (day) (year)
Cemetery or crematory: Evergreen, Brunswick
Location:
18. Funeral director: Chas N. Alexander
Address: 120 W McCulloh St
19. 10/24 (Date rec'd by registrar) 19 46 Albert R. Swackhamer Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24, 1946, at 9.15A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 6, 1946, to Oct., 24 1946 and that I last saw him alive on October 24, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Kunau, M.D. M.D. or other
Address: Henryton, Md. Date signed: 10/24/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4

CERTIFICATE OF DEATH

09866

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Finksburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Finksburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Maude W. Horner

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 1, 1880

8. AGE: Years	Months	Days	If less than one day
66	0	26	..... hrs. ..... min.

9. Birthplace: Finksburg, Md.
(Town, county, and state)

10. Usual occupation: General store

11. Industry or business

FATHER — 12. Name: George W. Horner

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Adelaide Wickert

15. Birthplace: Maryland

18. Informant: Mrs. Glenn Horner

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 10/30/46 (month) (day) (year)

Cemetery or crematory: Finksburg, Cemetery

Location: Finksburg, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 10/2[illegible] 46 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27 19 46, at 7p.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-1-30 19.., to 10-27- 19 46 and that I last saw h[illegible] alive on 10-26-46 19..

Immediate cause of death	DURATION
Myocarditis.	3 yrs -
Due to Hypertension -	10 yrs -
Arteriosclerosis.	10 yrs
Due to Diabetes -	10 yr
Chronic Nephritis.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James L. Sakell M. D. or other

Address: Reisterstown Md. Date signed 10/29/46

C9867

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 25 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 22 School House Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: LINWOOD JONES

3.(b) Social Security Number: 217-10-8901

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Alverta Jones
6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): November 3, 1911

8. AGE: Years	Months	Days	If less than one day
34	10	28	....hrs. ....min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business

FATHER
12. Name: Thomas Jones
13. Birthplace: Vienna, Maryland

MOTHER
14. Maiden name: Lottie Pickney
15. Birthplace: Vienna, Maryland

16. Informant: Deceased
Address: Cambridge, Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof Oct 7/46 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Cambridge, Md.

18. Funeral director: Lewis B. Jaynes
Address: Cambridge, Md.

19. Oct. 1, 1946
(Date rec'd by registrar)
Albert R. Twambley
Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1, 1946, at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6, 1946, to Oct. 1, 1946
and that I last saw h... im alive on October 1, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Wyman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 10-1-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09868 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 651 W. Fairmount Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: GRACE KENNEDY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 11, 1924

8. AGE: Years	Months	Days	If less than one day
22	1	3	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: Ernest Kennedy
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Maggie Brown
15. Birthplace: South Carolina

16. Informant: Deceased
Address:

17. Burial, cremation, or removal. Which? Burial Date thereof 10/17/1946 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location:

18. Funeral director: Adolphus Halsted
Address: 918 Druid Hill Ave

19. Oct. 14, 1946 (Date rec'd by registrar)
Albert A. Swanbrow Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14, 1946, at 4:10A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 12, 1946, to October 14, 46 and that I last saw her alive on October 14, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Unknown
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Deuel Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 10-14-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (34a)

(15) 69869

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs 11 mos 17 da
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 14 yrs 11 mos 17 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Calvert
City or town: Adelina
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Electra Kerney

3. (b) Social Security Number:

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: W widowed
6.(b) Name of husband or wife: Charles Kerney
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Sept 23 - 1867

8. AGE: Years: 69 | Months: | Days: 24 | If less than one day: hrs. min.

9. Birthplace: Illinois (Town, county, and state)
10. Usual occupation: housework
11. Industry or business: Private home
FATHER 12. Name: Charles Hill
13. Birthplace: Illinois
MOTHER 14. Maiden name: Sarah Hill
15. Birthplace: Illinois
16. Informant: Kenneth Kerney
Address: Adelina Md. Calvert
17. cremation (Burial, cremation, or removal. Which?) Date thereof: Oct. 21 1946 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln
Location: Mt. Washington, D. C.
18. Funeral director: C. Henry Weer
Address: Sykesville, Md.
19. Oct 21 1946 (Date rec'd by registrar) C. Henry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 17th 1946, at 7.55 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2 1931 to Oct 17 1946
and that I last saw h. alive on Oct 17th 1946

	DURATION
Immediate cause of death: Coronary Thrombosis	1 hr.
Due to:	
Due to: Arterio Sclerosis	15 yrs
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. H. Gaston M.D. M. D. or other
Address: Sykesville Md. Date signed: 10/17/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

09870 74

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 386 31st Street, Baltimore, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Charles Frank Kocourek

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna M. (nee Tricka)
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 5, 1873

8. AGE: Years	Months	Days	If less than one day
72 (?)			..... hrs. ..... min.

9. Birthplace: Czechoslovakia (Town, county, and state)
10. Usual occupation: Tailor
11. Industry or business: Haas Tailoring Co.

FATHER
12. Name: Frank Kocourek
13. Birthplace: Czech.

MOTHER
14. Maiden name: Marie Balik
15. Birthplace: Czech.

16. Informant: Records of Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/2/46 (month) (day) (year)
Cemetery or ~~Xxxxx~~: Oak Hill
Location: Horner's Lane, Baltimore, Md.

18. Funeral director: Charles E. Schimunek
Address: 2601-03 E. Madison St.

19. 11-1 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/29 19 46, at 7:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/24 19 46 to 10/29 19 46 and that I last saw him alive on 10/29 19 46

Immediate cause of death	DURATION
Cerebral Hemorrhage	18 hrs.
Due to: Cerebral Arteriosclerosis	unknown
Due to:	
Other conditions: Adenoma Prostate	5 days

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M. D. or other
Address: Springfield State Hospital, Sykesville, Maryland Date signed 10/29/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00871 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 20 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Doubs
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: DOROTHY ADELE LAWSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 4, 1917

8. AGE: Years	Months	Days	If less than one day
29	8	18	..... hrs. ..... min.

9. Birthplace: Doubs, Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: John Lawson
13. Birthplace: Doubs, Maryland

MOTHER
14. Maiden name: Ada Delauder
15. Birthplace: Jefferson, Maryland

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-24-1946 (month) (day) (year)
Cemetery or crematory: Sunnyside Col. A.M.E. Cem.
Location: Nr. Adamstown, Maryland
18. Funeral director: M.R. Etchison & Son
Address: Frederick, Maryland

19. Oct. 22, 1946 (Date rec'd by registrar) Albert R. Swanhart Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22, 1946, at 3:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2, 1946, to Oct. 22, 1946 and that I last saw her alive on October 22, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Reuben O. Swan, M.D. M. D. or other
Address: Henryton, Md. Date signed 10-22-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09872

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 29 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 717 S. Fremont Street
(If rurol, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: THOMAS ALBERT MAKER

3.(b) Social Security Number: 217-22-4775

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Mable Maker
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): June 15, 1906

8. AGE: Years	Months	Days	If less than one day
40	4	13	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Shoe Shiner
11. Industry or business:
FATHER 12. Name: Thomas Maker
13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Mary Rose Boyer
15. Birthplace: Unknown
16. Informant: Deceased
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-31-46 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Baltimore, Md
18. Funeral director: Isaac L Brown, Son
Address: 108 W Montgomery St
19. 10/28 19 46 (Date rec'd by registrar) Albert R Swanbaum Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28, 19 46 at 7.00 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 29, 19 46 to Oct. 28, 19 46
and that I last saw him alive on October 28, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 10/28/46

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09873 Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 3 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 665 Pierce Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: VIOLA MANDER

3.(b) Social Security Number: 215-05-7946

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 24, 1906

8. AGE: Years	Months	Days	If less than one day
40	7	8	hrs. min.

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation: Waitress

11. Industry or business:

FATHER
12. Name: Walter Mander
13. Birthplace: Philadelphia, Pa.

MOTHER
14. Maiden name: Ella Merritt
15. Birthplace: Maryland.

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-5-1946 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location:
18. Funeral director: Adolphus Halstead
Address: 918 Druid Hill Ave

19. 10/2 (Date rec'd by registrar) 19 46 Albert R. Grandstaff Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 2, 1946, at 4.00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 29, 1946, to Oct. 2, 1946 and that I last saw her alive on October 2, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W Swan, M.D.
M. D. or other
Address: Henryton, Md Date signed: 10/2/46

VS-415 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

09876

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 28 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Turners Station, Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 309 Bittern Court.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: WILLIE MILES

3.(b) Social Security Number: Lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 15, 1924

8. AGE:

Years	Months	Days	If less than one day
22	2	19	..... hrs. ..... min.

9. Birthplace: Great Falls, S. C.
(Town, county, and state)

10. Usual occupation: Railroad Laborer

11. Industry or business

FATHER
12. Name: George Miles
13. Birthplace: Unknown

MOTHER
14. Maiden name: Katie Wilmer
15. Birthplace: Unknown

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 8, 1946 (month) (day) (year)
Cemetery or crematory: Gladden Grove S. C.
Location: Chester S. C.

18. Funeral director: Elroy S. Wilson
Address: 1000 Brantly ave

19. 10/4 (Date rec'd by registrar) 1946 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4, 1946, at 11.15P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 6, 1946 to Oct., 4, 1946 and that I last saw him alive on October 4, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Reuben W. Howard, M.D. M. D. or other
Address: Henryton, Md. Date signed: 10/4/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09874

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months, 7 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 19 S. Dallas Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: BESSIE MORTON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married (sep.)

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September ? 1909

8. AGE: Years	Months	Days	If less than one day
37	1	?	hrs. min.

9. Birthplace: Raleigh, N.C. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER

12. Name: Bolery Stedman

13. Birthplace: Unknown

MOTHER

14. Maiden name: Emma ?

15. Birthplace: Unknown

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/18/46 (month) (day) (year)

Cemetery or crematory: Mt Calvery

Location: Brooklyn Md

18. Funeral director: Eldy O. Wilson

Address: 1000 Brantly ave

19. Oct. 14, 1946 (Date rec'd by registrar) Abbott R. Swanhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14, 1946 at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 7, 1945, to October 14, 46 and that I last saw her alive on October 14, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Md. Date signed: 10-14-46

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09875

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months, 19 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 19 S. Dallas Street
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: CHARLES MORTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 10, 1932

8. AGE:

Years	Months	Days	If less than one day
14	9	5	hrs. min.

9. Birthplace: Unknown (Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business:
FATHER 12. Name: Charles Morton
13. Birthplace: Unknown
MOTHER 14. Maiden name: Bessie Stedman
15. Birthplace: Unknown
16. Informant: Deceased
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/18/46 (month) (day) (year)
Cemetery or crematory: M. Calvey
Location: Brooklyn, Md
18. Funeral director: Elroy O. Wilson
Address: 1000 Beanty ave
19. Oct. 15, 1946 (Date rec'd by registrar) Albert R. Counihan Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 15, 1946, at 5:25 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 26, 1945, to Oct. 15, 1946
and that I last saw him alive on October 15, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10-3-45
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Foran, M.D. M. D. or other
Address: Henryton, Md. Date signed: 10-15-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply ... of information carefully. The correct age ... as of death clearly and legibly. ... is especially important. Physicians: please w...

09877

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town Manchester Md (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural Manchester Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles Harry Myers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ellen Myers
6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Dec. 30, 1870.

8. AGE: Years 75 | Months 9 | Days 8 | If less than one day ... hrs. ... min.

9. Birthplace Maryland Carroll Co.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Henry J Myers
13. Birthplace Maryland

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Jacob Myers
Address Millers Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-10-46 (month) (day) (year)
Cemetery or crematory St. Peters cemetery
Location St. Peters Baltimore Co.

18. Funeral director Jacob Winks Sons
Address Manchester Md

19. Oct. 9 1946 Mrs. W. P. S. Penner Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1946, at 2:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1945 to October 8 1946 and that I last saw him alive on Oct. 6 1946

	DURATION
Immediate cause of death Cerebral Hemmorrhage	3 days
Due to Hypertensive Cardio Vascular Disease	17 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Maurice C. Porterfield, M. D. or other
Address Hampstead Date signed 10-9-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9x4)

CERTIFICATE OF DEATH

Reg. Dist. No. 52

0878

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Near Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural--Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: CHARLES W. NAILL

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of ~~husband or~~ wife: Clara Naill
6.(c) If alive, give age: 55 years
7. Birth date of deceased (mo., day, yr.): Oct. 14, 1876

8. AGE: Years 70 | Months 0 | Days 9 | If less than one day: hrs. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Plasterer
11. Industry or business

FATHER
12. Name: Erias Naill
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Reaver
15. Birthplace: Maryland

16. Informant: Mrs. Clara Naill
Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 10-27-46 (month) (day) (year)
Cemetery ~~or crematory~~: Pine Grove
Location: Mt. Airy, Carroll Co. Maryland

18. Funeral director: C.M. Waltz
Address: Winfield, Md.

19. 10/24/46 (Date rec'd by registrar) Wm D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 23, 1946 at 9 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1 1946, to Oct 23 1946
and that I last saw h[illegible] alive on Oct 23 1946

Immediate cause of death	DURATION
Acute Cardiac Failure	
Probably Coronary	
Due to Chronic Endocarditis	
and Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. M. Waltz M. D. or other
Address: Mt Airy Md Date signed 10/24/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

09879

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 77 - 0 - 1

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. # 3

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Susan Alberta Orndorff

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Francis Orndorff

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 23 - 1869

8. AGE: Years	Months	Days	If less than one day
77	—	1	..... hrs. ..... min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name Amos Little

13. Birthplace Pa.

MOTHER

14. Maiden name Julia Ann Mathias

15. Birthplace Md.

16. Informant Mrs Paul Starner

Address Westminster, #3 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 27 - 1946 (month) (day) (year)

Cemetery or crematory Krider's Cemetery

Location Westminster, Md.

18. Funeral director H Bankard & Son

Address Westminster, Md.

19. 10 26 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1946 at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 1946 to Oct 23 1946 and that I last saw her alive on Oct 23 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J Thos D Stuart M. D. or other

Address Westminster Date signed Oct 26 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

09880

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County CARROLL
City or town HENRYTON
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, Institution, or street address where death occurred: MARYLAND TUBERCULOSIS SANATORIUM (COLORED BR.)
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County DORCHESTER
City or town VIENNA
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME OTTO PARKER

3.(b) Social Security Number 216-01-3868

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	COLORED	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JANUARY 12, 1908

8. AGE: Years	Months	Days	If less than one day
38	8	24	hrs. min.

9. Birthplace VIENNA, MARYLAND (Town, county, and state)
10. Usual occupation FACTORY WORKER
11. Industry or business CANNING INDUSTRY

FATHER
12. Name MORTON PARKER
13. Birthplace MARYLAND

MOTHER
14. Maiden name VIOLA BALL
15. Birthplace MARYLAND

16. Informant REUBEN HOFFMAN, M.D.
Address HENRYTON, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/9/46 (month) (day) (year)
Cemetery or crematory Fredericksburg
Location Fredericksburg, Md.
18. Funeral director J. Frampton
Address Fredericksburg, Md.

19. OCT. 6 1946 (Date rec'd by registrar) Albert A. Swanbrow deputy local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 6 1946, at 12:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 16 1946, to Oct. 6 1946 and that I last saw him alive on Sept. 6 1946

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	JUNE
Due to	1946
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.
M. D. or other
Address Henryton, Md. Date signed 10-6-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

*09881

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 9 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 12 W. All Saint Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MELENEE ELIZABETH PATTERSON

3.(b) Social Security Number: 213-20-2183

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Charles Patterson
6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): August 24, 1919

8. AGE: Years	Months	Days	If less than one day
27	1	29	..... hrs. ..... min.

9. Birthplace: Brunswick, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John Spriggs
13. Birthplace: Brunswick, Md.

MOTHER — 14. Maiden name: Marie Brooks
15. Birthplace: Brunswick, Md.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 26-1946 (month) (day) (year)
Cemetery or crematory: M.E.
Location: Petersville, Md
18. Funeral director: C. H. Keefe & Bro
Address: Brunswick, Md

19. 10/23 (Date rec'd by registrar) 19 46 Albert R. Stonebraker Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23, 1946 at 6.45 P.M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from August 14, 1946 to Oct. 23 1946
and that I last saw her alive on October 23, 1946

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Dec. 1945
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Swan M.D.
M. D. or other
Address: Henryton, Md. Date signed: 10/23/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45


RECEIVED
OCT 28 194
PORTLAND V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

CERTIFICATE OF DEATH

09882

Reg. Diat. No. 80

1. PLACE OF DEATH:

County Carroll

City or town Medford
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred: None

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Medford
(If outside city of town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Emma Shaner Poole

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Harry W Poole

6.(c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) March 24, 1875

8. AGE:

Years	Months	Days	If less than one day
71	7	5	..... hrs. ..... min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER
12. Name Not Known
13. Birthplace Not Known

MOTHER
14. Maiden name Not Known
15. Birthplace Not Known

16. Informant Harry W Poole

Address Medford Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 1, 1946 (month) (day) (year)

Cemetery or crematory Methodist Cemetery

Location Pleasant Valley Md

18. Funeral director D. D. Hartley & Son

Address Union Bridge Md New Windsor Md

19. Oct-31 1946 Emma D Bankert Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1946, at 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1- 1946, to Oct 29 1946 and that I last saw h.... alive on Oct 28 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	24 days
Due to Arterio Sclerosis	5 years
Due to Chronic Interstitial nephritis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. E Fouts M.D. M. D. or other

Address Westminster Md Date signed 10-31-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22-a)

CERTIFICATE OF DEATH

09883

Reg. Dist. No. 24

1. PLACE OF DEATH:
County Carroll
City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6yrs 8mo 13 da
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 6yrs. 8mo 13 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring (If outside city or town limits, write RURAL and give nearest town)
Street No. 903 Pershing Avenue (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME KATHERINE RITTER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female F	white	married

6.(b) Name of husband or wife Carl Ritter
6.(c) If alive, give age unkn years

7. Birth date of deceased (mo., day, yr.) September 8, 1876

8. AGE: Years 70 | Months 1 | Days 0 | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation housewife
11. Industry or business Home
FATHER 12. Name Daniel Donovan
13. Birthplace Ireland
MOTHER 14. Maiden name Unknown
15. Birthplace Maryland
16. Informant Hospital Records
Address Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 11 1946 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Suitland Md.
18. Funeral director Warren E. Humphrey
Address Silver Spring, Md.
19. Oct. 9 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8, 1946 at 6.45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8, 1940 19... to Oct. 8, 1946 and that I last saw her alive on October 8, 1946

	DURATION
Immediate cause of death	
Intestinal Obstruction --ventral	3 da.
Due to Hernia	
Due to	
Other conditions Psychosis with General	
Arteriosclerosis (Include pregnancy within 3 months of death)	6 yrs.

Major findings of operations Ventral hernia--massive intestinal adhesions-with obstruction of gut. Date of op. Oct. 8, 1946
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maud M. Rees M.D. M. D. or other
Address Sykesville Md. Date signed 10-8-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09884 B

Reg. Dist. No. 7K

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Nina Hope Rollins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Alonzo Rollins

6.(c) If alive, give age: Dec. years

7. Birth date of deceased (mo., day, yr.): 6/20/1877

8. AGE: Years	Months	Days	If less than one day
69	4	11	hrs. min.

9. Birthplace: Iowa
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: William Lyons
13. Birthplace: Iowa

MOTHER
14. Maiden name: Wilma ?
15. Birthplace: Iowa

16. Informant: Records of Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 4, 1946 (month) (day) (year)

Cemetery or crematory: Woodland

Location: Des Moines Iowa

18. Funeral director: Clarence F. Hoffmann

Address: 1639 N. Broadway

19. 11/1 1946 (Date rec'd by registrar) A. W. Heduck DM Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/31 1946, at 11:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/23 1946, to 10/31 1946 and that I last saw her alive on 10/31 1946

Immediate cause of death	DURATION
Lobar Pneumonia	3 days
Due to	
Due to	
Other conditions: Lobar Pneumonia, Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	1½ yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M. D. or other

Springfield State Hospital

Address: Sykesville, Maryland Date signed: 10/31/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09885

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 17 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mace's Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: ELSIE LOUISE ROSS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 10, 1912

8. AGE: Years	Months	Days	If less than one day
34	7	12	hrs. min.

9. Birthplace: Church Creek, Maryland
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Susan Ross
15. Birthplace: Unknown

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 31-1946 (month) (day) (year)
Cemetery or crematory: Church Creek
Location: Dorchester Co Md
18. Funeral director: Robert E Williams
Address: 1515 McElderry St

19. Oct. 22, 1946 (Date rec'd by registrar)
Albert R Secondhaver Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22, 1946 at 3:40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5, 1946 to Oct. 22, 1946 and that I last saw her alive on October 22, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept 1941
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lucas W Kenan, M. D.
M. D. or other
Address: Henryton, Md. Date signed: 10-22-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

★ 09886 Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yr., 4 mo., 25 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 8 yr., 4 mo., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Mt Lake Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Judson Runyan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 10, 1875

8. AGE: Years	Months	Days	If less than one day
71	3	25	hrs. min.

9. Birthplace: Marsdale, Pennsylvania (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business

FATHER
12. Name: Finnius Runyan
13. Birthplace: Fulton City, Pennsylvania

MOTHER
14. Maiden name: Caroline Mallott
15. Birthplace: Fulton City, Pennsylvania

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/9/46 (month) (day) (year)
Cemetery or crematory: Pleasant Valley Cem.
Location: Howard Co., Md.
19. Funeral director: Herbert C. Leighton
Address: Oakland, Md.

19. Oct 7 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 5 19 46 at 8:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 19 46 to October 5 19 46 and that I last saw him alive on October 5 19 46

Immediate cause of death	DURATION
Senility	12 years
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Howard N. Frederickson M.D.
M. D. or other
Address: Sykesville Md, Date signed: 10/6/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0988774

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 25 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1317 Woodyear Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ROSE LEE SEWELL

3.(b) Social Security Number: 219-12-5935

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 23, 1924

8. AGE: Years	Months	Days	If less than one day
22	0	22	hrs. min.

9. Birthplace: Lottsburg, Va. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Samuel Burrell
13. Birthplace: Lottsburg, Va.

MOTHER
14. Maiden name: Mary Scott
15. Birthplace: Lottsburg, Va.

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/18/46 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Brooklyn, Md.
18. Funeral director: Thomas E. Kelson
Address: Preston St.

19. Oct. 15, 1946 (Date rec'd by registrar) Albert R. Swandham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 15, 1946 at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20, 1946, to Oct. 15, 1946 and that I last saw her alive on October 15, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 10-15-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-21)

CERTIFICATE OF DEATH

09888 Reg. Diat. No. 74

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 7 mo 2 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 1 yr 7 mo 2 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)

State: Md. County: Washington

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Alice C Shindle

3.(b) Social Security Number:

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband: Wm Edward Shindle

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 23 - 1877

8. AGE: Years: 68 Months: 10 Days: 7 If less than one day: ..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

12. FATHER — Name: Wm C Eichelberger

13. FATHER — Birthplace: Clear Spring Md.

14. MOTHER — Maiden name: Harriet Bliss

15. MOTHER — Birthplace: Md.

16. Informant: Wm Edward Shindle

Address: Greencastle Pa

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct 30 1946 (month) (day) (year)

Cemetery or crematory:

Location: Greencastle Penna.

18. Funeral director: Jacob A Teeter

Address: Greencastle, Penna.

19. Oct 30 1946 (Date rec'd by registrar) C Harry Wm Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 30 1946, at 12 noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h ..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Suffocation -	
Due to: (b) Aspirating Meat into Trachea	
Due to: (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 10-30-46

Where did injury occur? Mt Carmel (City or town) Comb (County) Md (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Aspirated meat Injured at work? No

23. SIGNATURE: Jesse T Marsh M.D. Asst. Medical Exam M. D. or other

Address: Mt Carmel Md Date signed: 10/31/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0988?

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr, 6 mo's, 3 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9 Shaftsbury Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: WELFORD SIMPSON

3.(b) Social Security Number: 579-09-3460

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 10, 1910

8. AGE: Years	Months	Days	If less than one day
36	8	9	..... hrs. ..... min.

9. Birthplace: Kensington, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Joseph Simpson
13. Birthplace: Laytonsville, Md.

MOTHER
14. Maiden name: Bell Davis
15. Birthplace: Clarksburg, Md.

16. Informant: Deceased

Address

17. Buried (Burial, cremation, or removal. Which?) Date thereof oct 22 46 (month) (day) (year)

Cemetery or crematory: Brookgrove mountgomery co

Location: Layton Hills MD

18. Funeral director: Robert L Knowles

Address: Rockville md

19. 10/19 (Date rec'd by registrar) 19 46 Albert R. Swandale Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 19, 1946, at 6.55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16, 1945, to Oct., 19, 1946 and that I last saw him alive on October 19, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Nathan W Freeman, M.D.
M. D. or other

Address: Henryton, Md. Date signed 10/19/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09890 Reg. Diat. No. 7K

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yr., 10 mo., 20 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 20 yr., 10 mo., 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 421 S. Robinson Street
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Frederick Single

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M Male	W White	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): October 30, 1891

8. AGE: Years	Months	Days	If less than one day
54	11	9	hrs. min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation: Agent

11. Industry or business: Life insurance

FATHER 12. Name: Frederick Single

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Elizabeth Snyder

MOTHER 15. Birthplace: Baltimore, Maryland

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-13-46 (month) (day) (year)

Cemetery or crematory: Oak Lawn Cemetery

Location: Baltimore, Maryland

18. Funeral director: HENRY SANDER & SONS, INC.

Address: NORTH AVE. & BROADWAY

19. 10/12/46 (Date rec'd by registrar) Ave. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9, 1946, at 11:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1943, to October 9, 1946 and that I last saw him alive on October 9, 1946

Immediate cause of death	DURATION
General Paralysis of the Insane	24 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D. or other

Springfield State Hospital
Sykesville, Maryland
Address: Date signed 10-9-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

09891

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yr., 3 mo., 19 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 45 yr., 3 mo., 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Middleburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Harvey J. Smith

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1876

8. AGE: Years: 70 | Months: — | Days: — | If less than one day: hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER 12. Name: Gideon Smith

13. Birthplace: Pennsylvania

MOTHER 14. Maiden name: Martha Jane

15. Birthplace: Pennsylvania

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 16-46 (month) (day) (year)

Cemetery or crematory: Union Bridge Md. Quaker

Location: Union Bridge Md.

18. Funeral director: Raymond R. Knight

Address: Union Bridge. Md.

19. Oct 14 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 13 1946 at 4:28 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to Oct. 13 1946 and that I last saw him alive on October 13 1946

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	15 yrs
Due to:	
Due to:	
Other conditions: Schizophrenia, hebephrenic type (Include pregnancy within 3 months of death)	50 yrs.

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D. or other

Springfield State Hospital
Address: Sykesville, Maryland Date signed: 10-14-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 09892

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 27 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 929 N. Gay Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: THEODORE TALMER SMITH

3.(b) Social Security Number: 238-16-5467

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 22, 1918

8. AGE: Years	Months	Days	If less than one day
28	8	1	hrs. min.

9. Birthplace: Rose Hill, N. C.
(Town, county, and state)

10. Usual occupation: Barber

11. Industry or business

FATHER
12. Name: Ernest Smith
13. Birthplace: Rose Hill, N. C.

MOTHER
14. Maiden name: Rebecca Taylor
15. Birthplace: Rose Hill, N. C.

16. Informant: Deceased Than Smith
Address: 1 Langan St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/29/46 (month) (day) (year)

Cemetery or crematory:
Location: Mt. Olive, N.C.
18. Funeral director: Mrs. Lee H. Fuller
Address: 1631 Druid Hill Ave.

19. 10/23 (Date rec'd by registrar) 19 46 Albert M. Swarbaugh Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23, 1946 at 1.50P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 26, 1946 to Oct. 23, 1946 and that I last saw him alive on October 23, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 7, 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 10/23/46

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
NOV 2 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

★ 09893

Reg. Dist. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

1. PLACE OF DEATH:

County: Carroll

City or town: Uniontown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Uniontown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Minna Elise Spielman

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 12, 1878

8. AGE:

Years	Months	Days	If less than one day
68	7	11	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

MOTHER FATHER

12. Name: Charles Sitting

13. Birthplace: Germany

14. Maiden name: Louise Huntzman

15. Birthplace: Germany

16. Informant: Sterling Spielman

Address: Huntingdon Valley, Penna

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 28 1946 (month) (day) (year)

Cemetery or crematory: Lutheran Cemetery

Location: Uniontown

18. Funeral director: D.D. Hartzler & Sons

Address: New Windsor & Union Bridge, Md

19. Oct 26 1946 (Date rec'd by registrar) Margaret R. Engle, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23 1946, at 11:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 1946, to Oct 23 1946 and that I last saw her alive on October 23 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to: Arteriosclerosis	Years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Lauren F. Roach M.D. M. D. or other

Address: Westminster, Md Date signed: 10/24/46

Glos

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 09897 / 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Rural s. Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Rural s. Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Sarah Elizabeth Sproul

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	W.

6.(b) Name of husband or wife Nelson S Sproul
6.(c) If alive, give age —

7. Birth date of deceased (mo., day, yr.) May 29, 1867

8. AGE:	Years	Months	Days	If less than one day
	79	5	25	hrs. min.

9. Birthplace Providence, Balto. md
(Town, county, and state)
10. Usual occupation House wife
11. Industry or business —

MOTHER
12. Name —
13. Birthplace —

FATHER
14. Maiden name Sarah E Phyllis
15. Birthplace Towson

16. Informant Mrs. Annie E Jackson
Address Rural s. Westminster

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 27, 1946 (month) (day) (year)
Cemetery or crematory Grace
Location Chestnut Ridge Falls Road.

18. Funeral director Wm Berryman & Sons
Address Reisterstown

19. 10/26 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27/46 19 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1- 19 38 to 10-27- 19 46
and that I last saw her alive on 9/1/46 19

Immediate cause of death	DURATION
Coronary Thrombosis	2 h.
Due to Hypertension	
Due to Arteriosclerosis	
Other conditions Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James G Sadler M. D. or other
Address Reisterstown Date signed 10/26/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

CERTIFICATE OF DEATH

09895

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Rural, Frederick, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: CORRINE IRENE SQUIREL

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 8, 1917

8. AGE: Years	Months	Days	If less than one day
29	1	22	hrs. min.

9. Birthplace Westminster, Md.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER
12. Name Norris P. Squirrel
13. Birthplace Westminster, Md.

MOTHER
14. Maiden name Effie Black.
15. Birthplace Westminster, Md.

16. Informant Ruth Costley
Address 6228 Falls Rd. Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 1 46 (month) (day) (year)
Cemetery or crematory Western Chapel Cem.
Location near Westminster, Md.

18. Funeral director E. Myers Jr.
Address Westminster, Md.

19. 10/30 (Date rec'd by registrar) 19 46 Albert R. Swandham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30, 1946, at 6.55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 14, 1946, to Oct., 30, 1946 and that I last saw her alive on October 30, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Declan W. Furman M.D. M. D. or other
Address Henryton, Md. Date signed 10/30/46

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-5


RECEIVED
1945
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09896

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 yr., 6 mo., 24 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 48 yr., 6 mo., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Charles Stahn

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 21, 1862

8. AGE: Years	Months	Days	If less than one day
84	6	11	hrs. min.

9. Birthplace: Baltimore City, Maryland (Town, county, and state)

10. Usual occupation: Watchmaker

11. Industry or business:

FATHER 12. Name: Matthew Stahn

FATHER 13. Birthplace: Poland

MOTHER 14. Maiden name: Katherine Lance

MOTHER 15. Birthplace: Germany

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-2-46 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Oct. 2 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 2 1946 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1 1943 to October 2 1946 and that I last saw him alive on October 1 1946

Immediate cause of death	DURATION
Bronchopneumonia	1 week
Due to Arteriosclerosis	13 yrs.
Due to	
Other conditions Dementia precox, hebephrenic type	49 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: See cause of death above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D. M. D. or other

Springfield State Hospital

Sykesville, Maryland

Address: Date signed 10-2-46

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37)

09897

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs., 10 mo., 28 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 20 yr., 10 mo., 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Unk.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Jacob Staub

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

B.(b) Name of husband or wife

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1884

8. AGE: Years: 62 | Months: ✓ | Days: ✓ | If less than one day: ..... hrs. ..... min.

8. Birthplace: Frederick County, Maryland (Town, county, and state)

10. Usual occupation: farmer

11. Industry or business: agriculture

FATHER

12. Name: Randolph Staub

13. Birthplace: Maryland

MOTHER

14. Maiden name: Susie Fox

15. Birthplace: Frederick County, Maryland

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-2-46 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Wm

Address: Sykesville, Md.

19. Oct. 2 1946 (Date rec'd by registrar) C. Harry Wm Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1 19 46 at 12:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1943 19 to October 1 19 46 and that I last saw him alive on September 30 19 46

Immediate cause of death	DURATION
Pyelonephritis	2 weeks
Due to Chronic myocarditis & myocardial degeneration	indef.
Due to	
Other conditions Dementia precox, hebephrenic type	32 yr.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: See cause of death above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.

M. D. or other

Springfield State Hospital

Address: Sykesville, Maryland

Date signed 10-2-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09898 77

Reg. Diat. No.

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lena Anna Switzer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Harry S Switzer

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Nov 1 - 1874

8. AGE: Years	Months	Days	If less than one day
71	11	2	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

MOTHER FATHER

12. Name: Charles Claes

13. Birthplace: Germany

14. Maiden name: Maggie Theirt

15. Birthplace: Maryland

16. Informant: Harry S Switzer

Address: Hampstead Md R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 6/46 (month) (day) (year)

Cemetery or crematory: Sykesville

Location: Carroll Co Md

18. Funeral director: Edw S Tipton

Address: Hampstead Md

19. Oct. 5 1946 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 3 1946 at 12:30 p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 1941 to Oct 3 1946 and that I last saw h.er alive on Oct 2 1946

Immediate cause of death	DURATION
Arterio-Sclerotic	
Cardio-Vascular disease	6 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Mamie C. Pontefract M. D. or other

Address: Hampstead, Md Date signed: 10-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 09899

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 month, 15 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Talbot
City or town: Easton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 206 Hanson Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: GEORGE THOMAS

3.(b) Social Security Number: 213-22-7495

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 10, 1922

8. AGE: Years: 24 Months: 6 Days: 13 If less than one day: hrs. min.

9. Birthplace: Denton, Md.
(Town, county, and state)

10. Usual occupation: Cannery Worker

11. Industry or business:

FATHER
12. Name: Samuel Thomas
13. Birthplace: Unknown

MOTHER
14. Maiden name: Novella Gale
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 26 '46 (month) (day) (year)
Cemetery or crematory: Bayhaven Cemetery
Location: Easton Md.
18. Funeral director: John L. Williams
Address: Easton Md.

19. 10/23 19 46 (Date rec'd by registrar) Albert R. Swanbham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23, 19 46 at 3.55P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 8, 19 46 to Oct. 23 19 46
and that I last saw him alive on October 23, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 1939
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Swan, M.D. M. D. or other
Address: Henryton, Md. Date signed: 10/23/46

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09900

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 182 E. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Betty Devilbiss Thorne

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Samuel Thorne

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 28, 1873

8. AGE: Years	Months	Days	If less than one day
73	4	24	hrs. min.

9. Birthplace: Woodsboro, Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: John Wesley Devilbiss

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Nancy Ann Wood

15. Birthplace: Maryland

16. Informant: Mrs. Walter L. Taylor

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 10/24/46 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 10/23/46 (Date rec'd by registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 19 46 at 5:30 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 2 19 46 to Oct 22 19 46

and that I last saw her alive on October 17, 19 46

Immediate cause of death: Cancer of breast with metastasis to pulmonal organs — DURATION 18 mos

Due to:

Due to:

Other conditions:

(Incinde pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Francis Reese M. D. or other

Address: Westminster Md. Date signed: 10/27/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09901

Reg. Diat. No. 24

1. PLACE OF DEATH:
County Carroll
City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 yrs and 14 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital-Sykesville-Md.
How long in hospital or institution? 33 yrs and 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 43 LaSalle Avenue (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
LUCY (LOUISE) S. Walter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29, 1871

8. AGE: Years	Months	Days	If less than one day
75	5	29	hrs. min.

9. Birthplace Baltimore, Maryland (town, county, and state)
10. Usual occupation none John Walter
11. Industry or business Germany
FATHER 12. Name Catherine Schuster
13. Birthplace Germany
MOTHER 14. Maiden name Hospital Records
15. Birthplace Sykesville, Maryland.
16. Informant
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 30, 1946 (month) (day) (year)
Cemetery or crematory Springfield Hosp. Cem.
Location Sykesville, Md.
18. Funeral director C. Harry Zieer
Address Sykesville, Md.
19. Oct. 30 19 46 C. Harry Zieer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1946 at 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1946, to Oct. 27 1946 and that I last saw her alive on October 26, 1946

Immediate cause of death	DURATION
Arteriosclerosis and myocardial degeneration	8 years
Due to	
Due to	
Other conditions Schizophrenia--paranoid Type	43 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

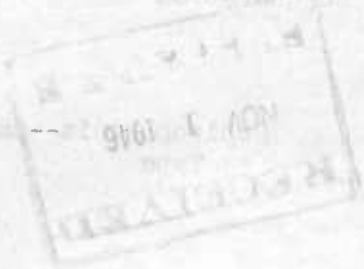
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maud M. Rees M. D.
M. D. or other
Address Sykesville, Md. Date signed 10-27-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

#9902

Reg. Diat. No. 87

1. PLACE OF DEATH:

County: Carroll

City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Rural - Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Miss William M. Webb

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Nov. 14, 1876

8. AGE: Years: 69 | Months: 11 | Days: 8 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Howard Co. Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: David Webb
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Georgia V. Stackhouse
15. Birthplace: Maryland

16. Informant: Mr. Harry R. Webb
Address: Mt. Airy, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-25-46 (month) (day) (year)

Cemetery or crematory: Family

Location: Poplar Springs, Howard Co. Md

18. Funeral director: C. M. Wells

Address: Winfield Md

19. 10/24 1946 Wm E. Snyder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 22 1946, at 5:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7 1946 to Oct 22 1946 and that I last saw h.. alive on October 22 1946

Immediate cause of death	DURATION
Cardiac Insufficiency	4 hrs
Due to: Chr. Myocarditis	6 yrs
Due to: Bronchial Asthma	? yrs ??
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other

Address: Mt Airy - Md Date signed 10/23/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
OCT 26 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09903

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years, 6 months, 20 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1045 N. Chapel Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: RUFUS WILLIAMSON

3.(b) Social Security Number: 714-18-0366

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Mary Williamson
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 7, 1915

8. AGE: Years	Months	Days	If less than one day
31	5	26	..... hrs. ..... min.

9. Birthplace: Columbus, S.C.
(Town, county, and state)
10. Usual occupation: Fireman
11. Industry or business

FATHER
12. Name: Evel Williamson
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Clotel Posey
15. Birthplace: South Carolina

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 7 1946 (month) (day) (year)
Cemetery or crematory: Mount Calvary
Location: annapolis Road
18. Funeral director: Mrs Robert Elliott - daughter
Address: 1129 N. Caroline St.

19. Oct. 3, 1946 (Date rec'd by registrar) Albert R. Swandstrom Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 3, 1946, at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13, 1942 to Oct. 3, 1946 and that I last saw him alive on October 3, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1942
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Denham Williams M.D. M. D. or other
Address: Henryton, Md. Date signed: 10-3-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09904

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 16 North Bond Street
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: DANIEL WILSON

3.(b) Social Security Number: 218-07-9487

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1904

8. AGE: Years	Months	Days	If less than one day
42	3	4	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Chauffeur

11. Industry or business

FATHER
12. Name Charles Wilson
13. Birthplace Maryland

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 15, 1946 (month) (day) (year)
Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md
18. Funeral director Elroy V. Wilson
Address 1001 Brantley ave

19. 10/12 (Date rec'd by registrar) 19 46 Albert R. Swankham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 19 46 at 9.10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept., 28, 19 46, to Oct., 12, 19 46
and that I last saw him alive on October 12, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben W. Kenan, M.D.
M. D. or other
Address Henryton, Md. Date signed 10/12/46

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09905 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs, 20 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1624 Lorman Court

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: CARRIE ELIZABETH WINDLEY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: James Ulyless Windley

6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): November 14, 1916

8. AGE: Years	Months	Days	If less than one day
29	11	17	..... hrs. ..... min.

9. Birthplace: Chocowinity, N. C. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Jessie Small

13. Birthplace: Chocowinity, N. C.

MOTHER — 14. Maiden name: Julia Moore

15. Birthplace: Chocowinity, N. C.

16. Informant: Deceased

Address:

17. (Burial, cremation, or removal. Which?) Burial Date thereof Nov 5 46 (month) (day) (year)

Cemetery or crematory: Mt Olivet Cemetery

Location: Bath Md

18. Funeral director: Kate J Mullin

Address: 3 E Biddle St Baltimore Md

19. 10/31 19 46 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31, 1945 at 10.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 11, 1943, to Oct. 30, 1946 and that I last saw her alive on October 31, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1942
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 10/31/46

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

09906

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yr. 2 mo. 16 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 9 yr. 2 mo. 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: George William Samuel Wirsing

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 23, 1884

8. AGE: Years	Months	Days	If less than one day
61	11	24	hrs. min.

9. Birthplace: Kingsville, Baltimore Co.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER 12. Name: Everhart Wirsing
13. Birthplace: Germany (?)

MOTHER 14. Maiden name: Mary Rogers
15. Birthplace: Harford Co., Maryland

16. Informant: Springfield State Hospital Records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Oct. 19, 1946 (month) (day) (year)
Cemetery or crematory: Springfield State Hosp. Cem.
Location: Sykesville, Md.

18. Funeral director: C. Harry Weer
Address: Sykesville, Md.

19. Oct. 19, 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17, 19 46, at 1:10a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1, 19 43, to Oct. 17, 19 46
and that I last saw him alive on October 16, 19 46

Immediate cause of death	DURATION
Cerebral hemorrhage	4 days
Due to	
Due to	
Other conditions: Schizophrenia, paranoid type. (Include pregnancy within 3 months of death)	9 yrs.

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May M.D. M. D. or other
Address: Sykesville, Md. Date signed: 10-9-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10-E)

09907

CERTIFICATE OF DEATH

Reg. Diat. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: near Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural--- Mt. Airy
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Bessie Francis Wright, Bessie Francis

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William Earl Wright

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 22, 1897

8. AGE:	Years	Months	Days	If less than one day
	48	11	20	hrs. min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: William J. Grimes
13. Birthplace: Maryland

MOTHER
14. Maiden name: Edna R. Warfield
15. Birthplace: Maryland

16. Informant: Mr. Earl Wright
Address: Mt. Airy, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-16-46 (month) (day) (year)
Cemetery or crematory: Taylorsville
Location: Taylorsville, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. 10/4/46 (Date rec'd by registrar) 19 46 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12 1946 at 11:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Fractured Skull	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of Oct 12-46
Where did injury occur? Westminster Carroll Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Auto accident Injured at work?

23. SIGNATURE: James T. Roach Deputy Medical Examiner
M. D. or other
Address: Westminster Md Date signed Oct 12-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09908

Reg. Diat. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: near Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Rural --Mt. Airy
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Martin Grimes Fowler Wright

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 10, 1931

8. AGE: Years: 15 | Months: 3 | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: In School

11. Industry or business

FATHER
12. Name: Richard Fowler
13. Birthplace: Maryland

MOTHER
14. Maiden name: Marybelle Grimes
15. Birthplace: Maryland

16. Informant: Mr. Earl Wright
Address: Mt. Airy, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-16-46 (month) (day) (year)
Cemetery or crematory: Taylorsville
Location: Taylorsville, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. 10/18- 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12 1946 at 10:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Crushing injury to chest	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 10-12-46
Where did injury occur? Westminster (City or town) Carroll (County) Md. (State)
Injured at home, farm, industry, public place (where?): Route 27
Means of injury: Auto. accident Injured at work?

23. SIGNATURE: James T. Howard, Deputy Medical Examiner
M. D. or other
Address: Westminster Md. Date signed: Oct. 12. 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

09909

Reg. Dist. No. 75 0

1 2

1. PLACE OF DEATH:

County Carroll

City or town Manchester (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Manchester (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph G. Yingling

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of ~~husband~~ or wife Caroline Yingling

6.(c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) July 23 1866

8. AGE: Years	Months	Days	If less than one day
80	3	4	....hrs. ....min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Thos Yingling

13. Birthplace Md

MOTHER 14. Maiden name Louise Sykes

15. Birthplace Penna.

16. Informant Mrs Jos G Yingling

Address Manchester, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 27/46 (month) (day) (year)

Cemetery or crematory Manchester

Location Carroll Co., Md

18. Funeral director Edw C Tipton

Address Hampstead Md

19. Oct. 25 1946 (Date rec'd by registrar) M.D.W.P.S. Denver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1946, at 9:30 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 24 1945 to Oct 24 1946

and that I last saw him alive on Oct. 23 1946

Immediate cause of death	DURATION
Carcinoma of Stomach	9 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maurice C. Porterfield M. D. or Other

Address Hampstead, Md Date signed Oct 25/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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